Individual Consumer - Prescription Drug Complaint

Attn: PBM Unit **Tracking ID:**

Alabama Department of Insurance
Insurance Consumer Services Division
201 Monroe Street, Suite 502 | Montgomery, AL 36104

(334) 241-4141 phone | (334) 956-7932 fax
ConsumerServices@insurance.alabama.gov

State Use Only

(PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

Section I: Before you file a Request for Assistance

You should first contact the Health Insurer for your Prescription Drug Plan and attempt to resolve the issue(s). If you do not receive a satisfactory response, then fill out an Individual Consumer Prescription Drug Complaint Form. Complete this form and attach copies of any appeal denial and any important correspondence and/or documentation that relates to your request for assistance. **MAIL, email, or fax forms** to the appropriate address shown above.

Individual Consumer – Prescription Drug Complainant

Individual Complainant (if individual filing)	Pharmacy Name	& Contact Person
Address	Address	Work Phone
City, State, Zip	City, State, Zip	Cell
Email Phone	Email	Email

Section II: General Information

1. **Name of Pharmacy Benefit Manager**: _____
2. Name of Insurance Company: _____
   a. What state did you live in when you purchased this policy? _____
3. Name of Physician/Prescriber: _____

   Covered Individual: _____ a. CI id/Plan #: _____

   b. Date of Birth _____ c. Rx # _____ d. Drug Name: _____

   e. Claim # _____
4. Are you represented by legal counsel? **(Check One)** ☐ Yes ☐ No

   If yes, name of Attorney: _____
5. Does your complaint involve a **Self-Funded Health Benefit Plan**? **(Check One)** ☐ Not sure ☐ Yes ☐ No

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Section III: PBM Problem

6. Describe your Complaint Problem in Detail (use additional paper, if needed):
   - Provide Prescription Receipts and other detailed documentation supporting your complaint.
   - **SIGN** this Complaint Form before filing.

What do you consider to be a fair resolution?

The Insurance Commissioner is authorized to send a copy of this complaint and any follow-up documents to any Insurance Company or Pharmacy Benefit Manager involved in the complaint to investigate my concerns. I authorize the release of all relevant information, including medical records, to the Insurance Commissioner's office for its review of this matter. I understand the Insurance Commissioner's office cannot act as my attorney, cannot file a private action on my behalf, and cannot provide legal advice or evaluate claims. I further understand and agree that the contents herein may be forwarded to other appropriate state or federal agencies, as well as become accessible to others under Alabama open records laws unless the investigation is under the Alabama Pharmacy Benefits Manager Licensure and Regulation Act (Title 27, Chapter 45A, Code of Alabama 1975). Also, I declare and verify that all the above information is true and correct to the best of my knowledge.

X _____ _____

Individual Complainant Signature (if filing individually) Date